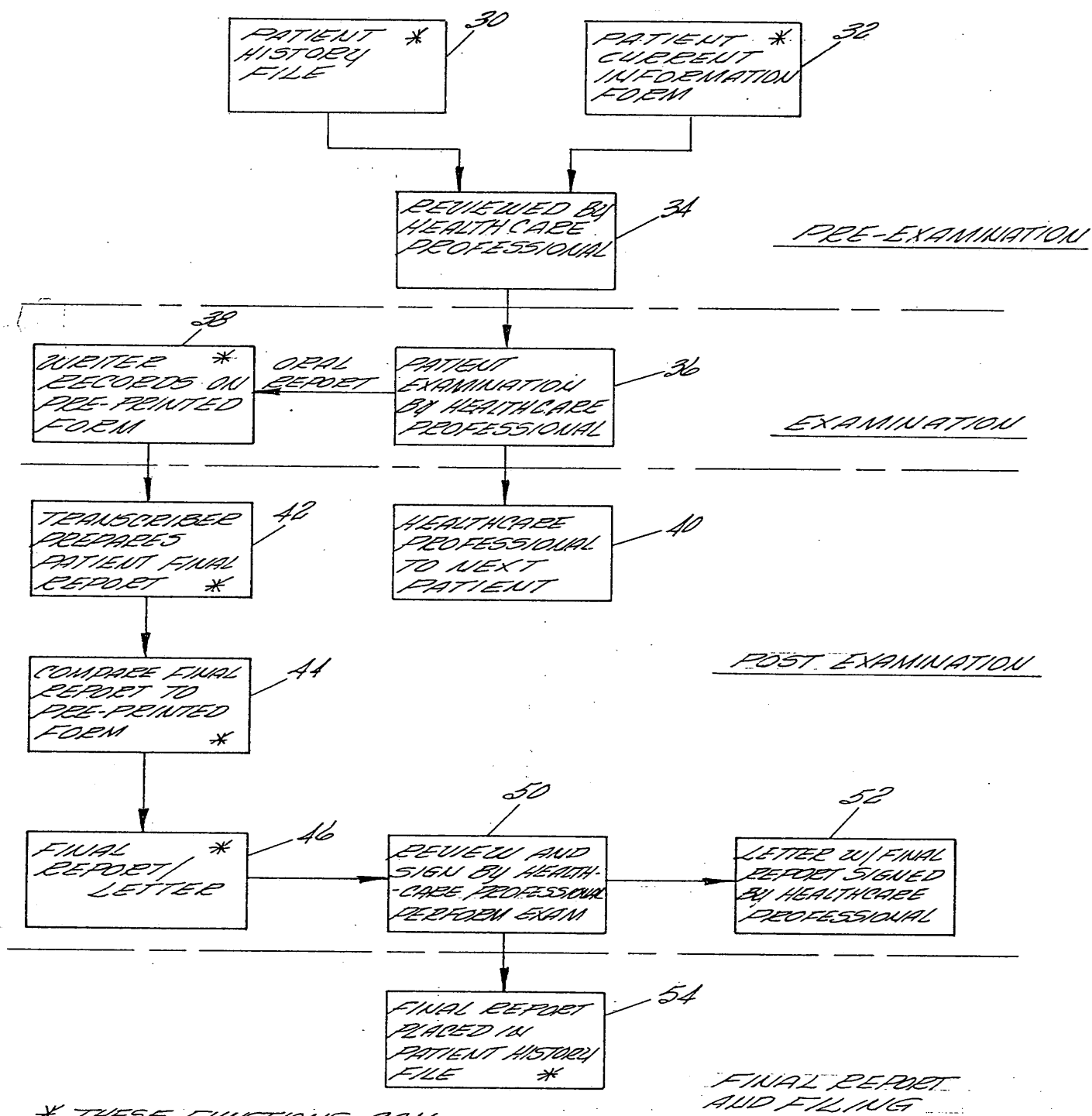


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* THESE FUNCTIONS CAN
BE PERFORMED WITH A
COMPUTER INPUT DEVICE,
COMPUTER & SOFTWARE

Fig 1

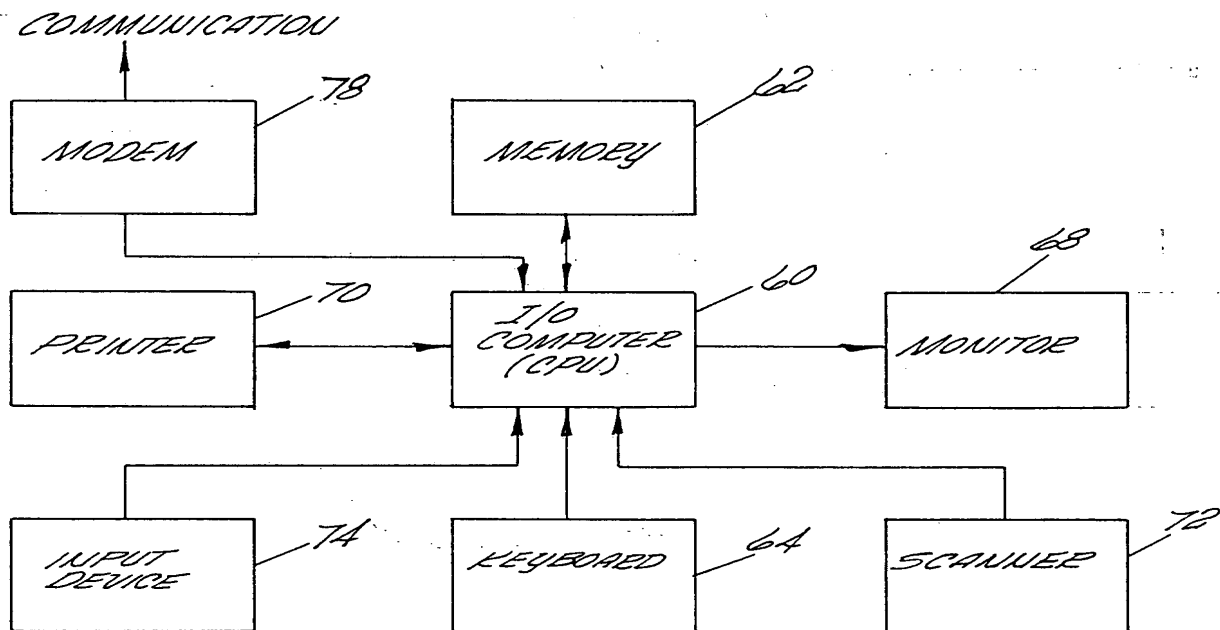


Fig 2

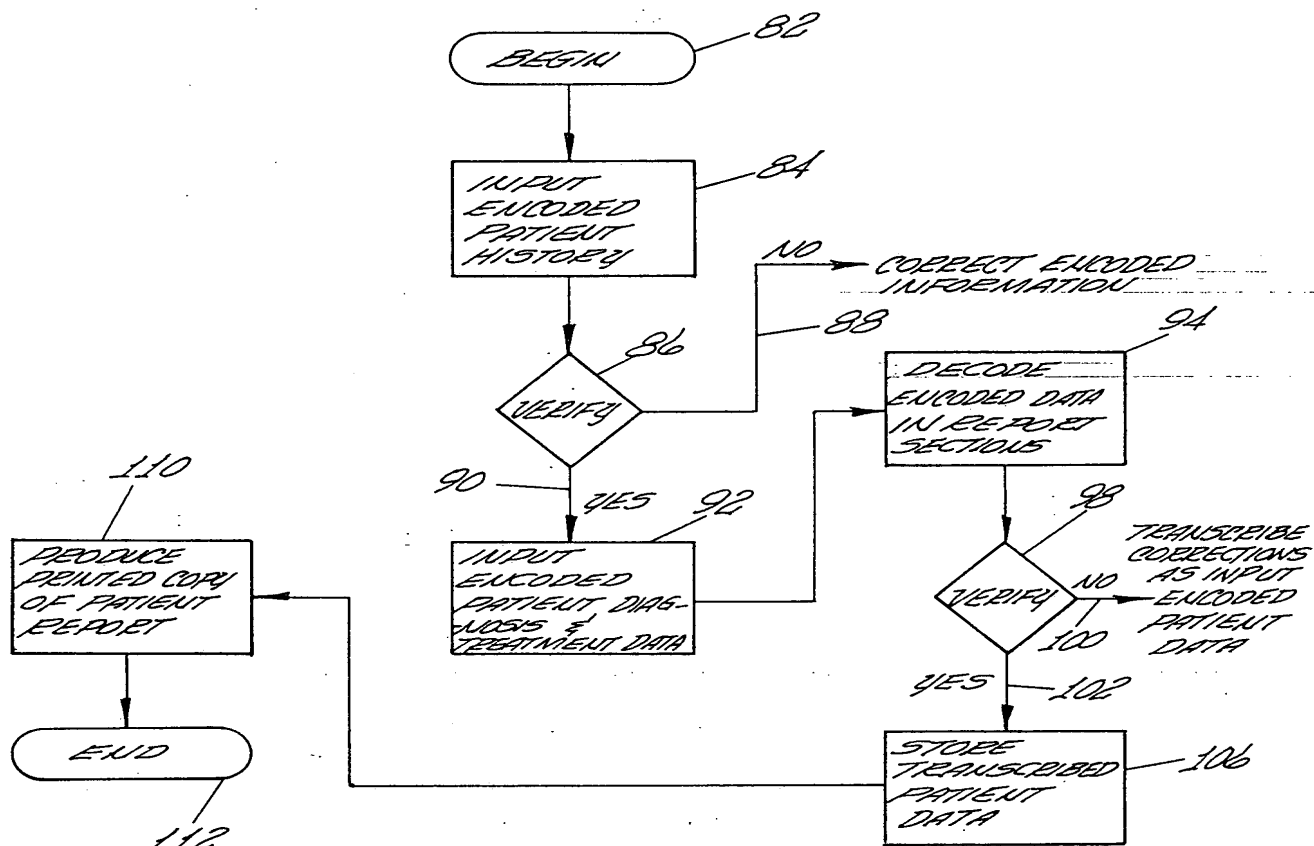


Fig 3

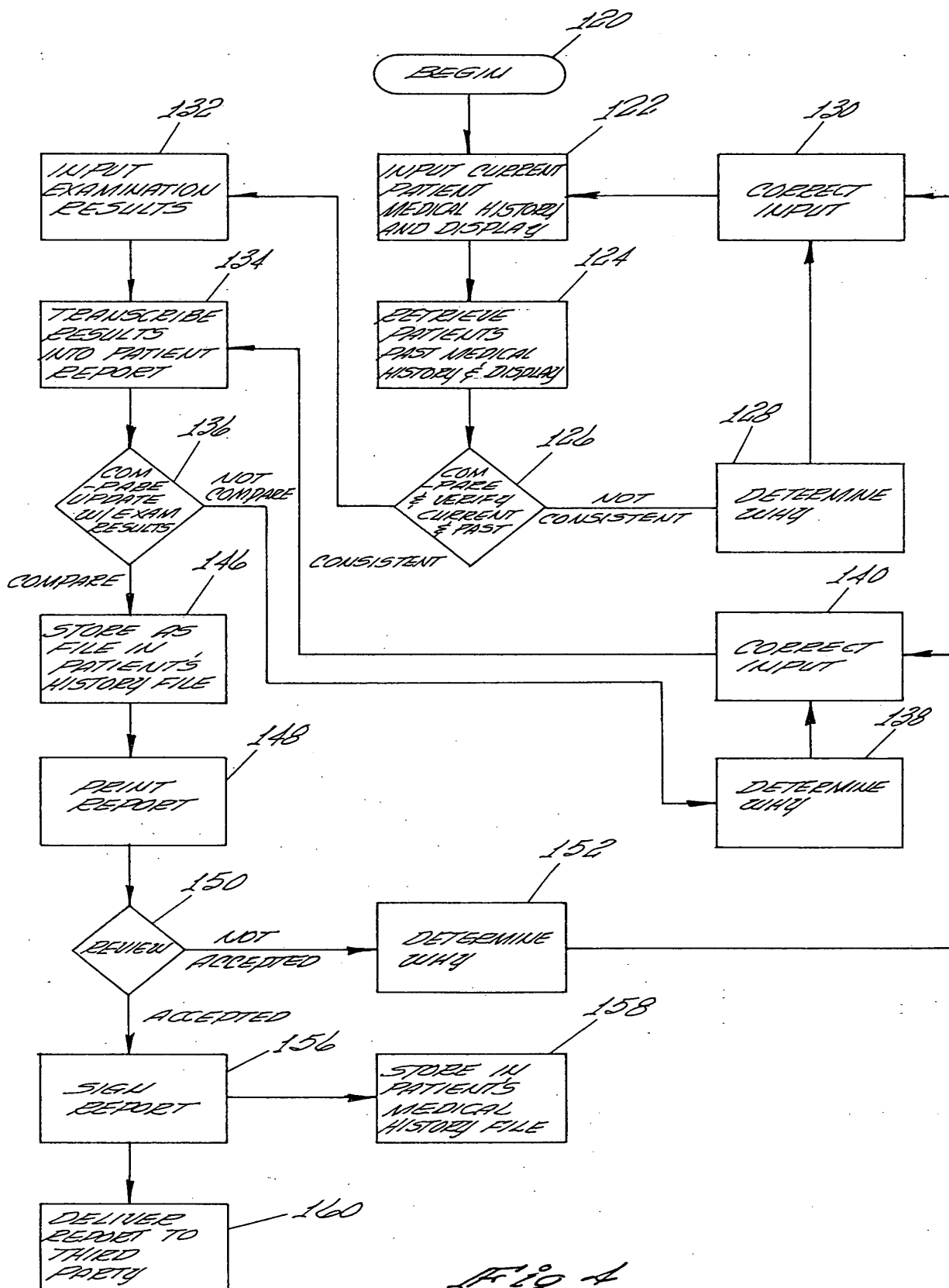


Fig 4

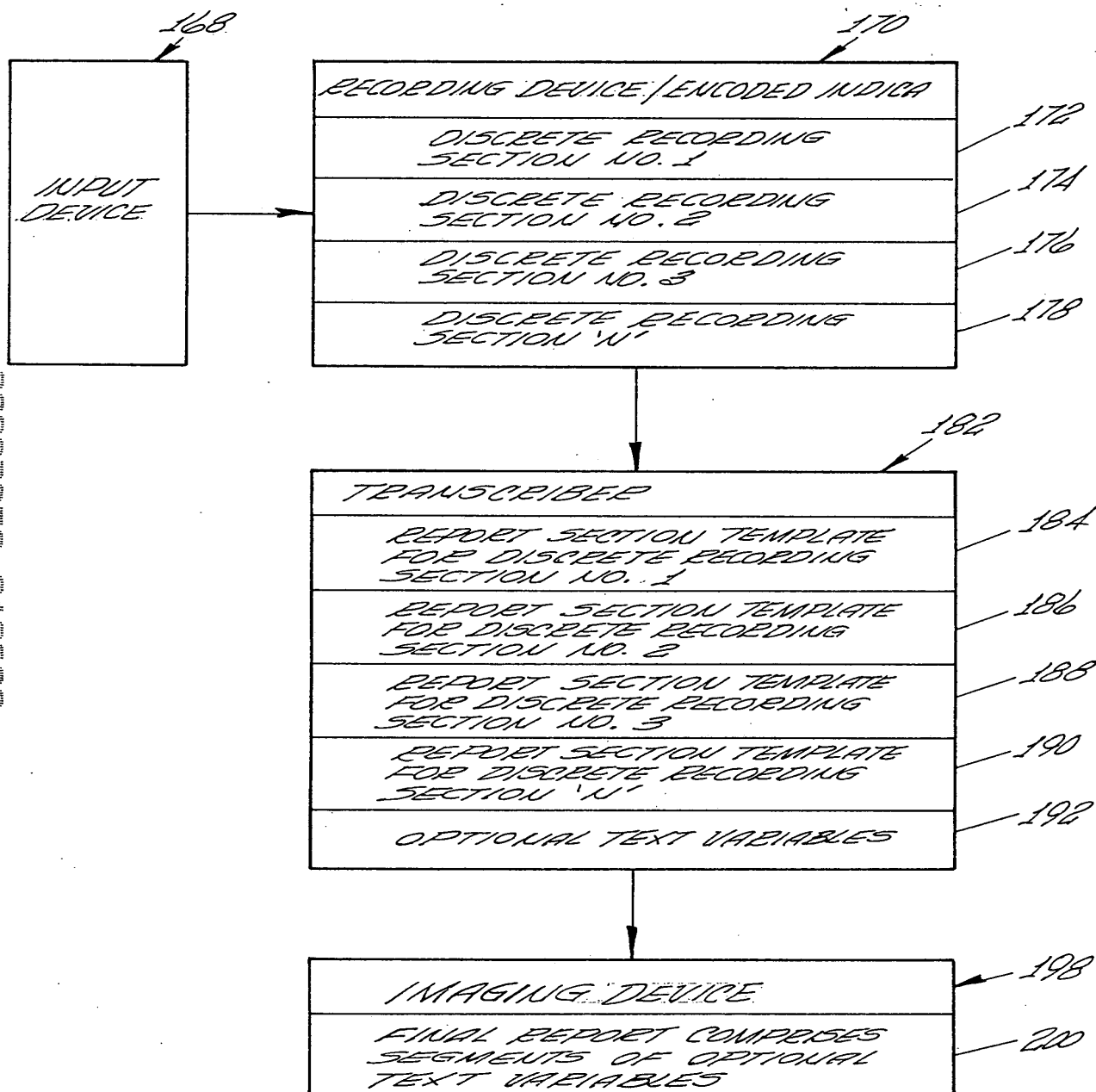


Fig 5

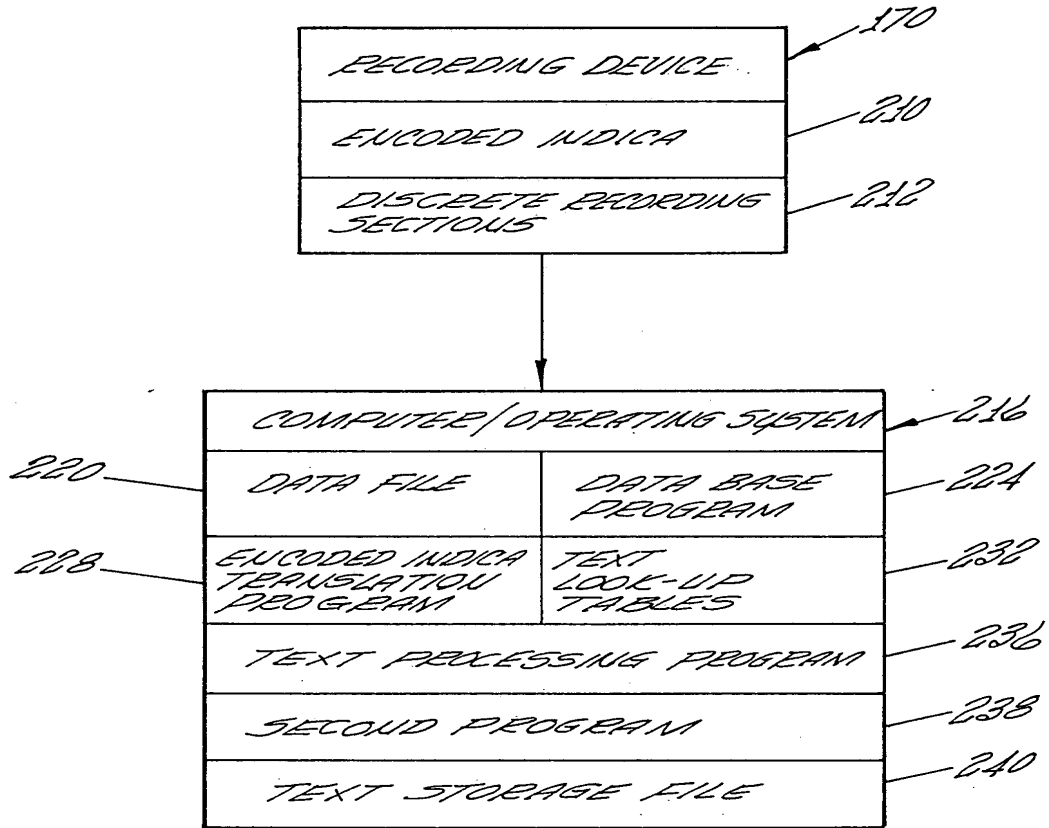


Fig 6

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Name:	Age:	Ht:	Wt:	P:	R:	Temp:	LMP	Date	w/u	wr	prov
<div style="display: flex; justify-content: space-between;"> <div> <p>CC:</p> <p>BP L R</p> <p>St</p> <p>SI</p> <p>Ly</p> <p>Allergies:</p> </div> <div> <p>Rec Lab:</p> </div> </div>											
<p>Circle any examined, note norms Enter # of abn, indicate findings</p>											
<p>1. Gen, skin:</p> <p>2. HEENT:</p> <p>3. Neck:</p> <p>4. Heart:</p> <p>5. Lungs: wheezes ronchi rales</p> <p>6. Breasts:</p> <p>7. Abdomen: tend, mass, bs + - guarding, rebound</p> <p>8. Rectal:</p> <p>9. Pelv (F):</p> <p>Genital (M):</p> <p>10. Musc-skel:</p> <p>11. Neuro: reflexes</p> <p>12. Other:</p>											
<p>Lab: RDS FBS HgbA1c CBC Renal Lipid SNAC UA Thy TSH</p> <p>Wcht Pap Chlam Gc RPR HIV ESR Other:</p>											
<p>X-ray U/S CT MRI of mammo other:</p>											
<p>Assessment:</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p>											
<p>Plan:</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p>											
<p>RTC D W M Y for Ref F T</p>											

258

256 Fig 7

NAME:	DATE:	ANNUAL and NEW PATIENT
<p>New Patient</p> <p>Annual</p> <p>Current problems:</p> <p>Current Medications:</p> <p>Treated by another physician:</p> <p>Who and why:</p> <p>Past medical history:</p>	<p>Last Pap:</p> <p>Class:</p>	<p>FOR ANNUAL ONLY:</p> <p>Any serious illness or operations in the past year:</p> <p>Any family members seriously ill in past year:</p>
<p>IMPRESSION:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p>		
<p>BIRTH CONTROL METHOD</p> <p>PLAN: () Monagyn () TOC in 10 days</p> <p>Mode:</p> <p>Procedures:</p> <p>Other:</p> <p>Return to clinic: () 6 months () 1 year</p> <p>For recheck in () days () weeks () months</p>		
<p>None needed</p> <p>() Premarin .825 / 100 x 1</p> <p>() Provera 10 mg # 30 x 1 refill</p> <p>() Northingdrene acct 5 mg # 30 x 1</p> <p>() 1 po qd 1-25 cycle</p> <p>() 1 po qd 1-25 cycle</p>		

Fig 8

274 276

270

W/C ___ P/I ___ Home Related ___ Sports Related ___ School ___

280

282

-286

-268

627

Fig 10

NEW PATIENT HISTORY
OR
ESTABLISHED PATIENT WITH A NEW INJURY

Name: _____

W/C ____ P/I ____ Home Related ____ Sports Related ____ School ____

History of the Injury: _____

Injured area: _____

When: _____

Where: _____

Injury as it occurred: _____

Where treated:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Tests, X-rays and/or surgeries done: _____

Referred by: _____

PATIENT INFORMATION SHEET (NEW W/C RETURN POST-OP OSTRO)

SURGERY, Type: _____ Date: _____

Last Name: _____

First Name: _____

Race: 0 SP-C C N Male Female

Job Description: _____

Requires: Bending Scooping Twisting Reaching Standing Walking

ALLERGIES, N/A

CURRENT MEDICATIONS, NONE

SHOULD THIS REPORT BE IN LETTER STYLE? Yes no

If yes, where should additional letter be sent?

Attorney _____ Referring Physician _____ Other _____

Which body part(s) are injured?

Cervical spine, Shoulder, Elbow, Wrist, Hand, Fingers, Thoracic spine, Lumbar spine, Hip, Knee, Ankle, Foot, Toe

Date of last visit: _____

Prior Tests and results: _____

Medication since last visit: _____

Physical Therapy since last visit: _____

Does the patient have pain which awakens them at night? yes no

If yes, number of times: _____

ACTIVITY RECORD (W/C ONLY)

Patient can do the following: Lift _____ lbs

Sit for _____ hrs _____ min. Kneel N O F

Stand for _____ hrs _____ min. Climb N O F

Walk for _____ hrs _____ min. Bend N O F

Ride in Car _____ hrs _____ min. Twist N O F

PAIN DESCRIPTION: _____ R L RL

Pain Description: Throbbing Stabbing Burning Dull/Aching

Sharp

Radiation (Cervical and lumbar): Shoulder R/L Arm R/L Hand R/L

Buttock R/L Thigh R/L Calf R/L Foot R/L

Pain is made worse with cough or sneeze? yes no

Loss of control of bowel or bladder? yes no

Other symptoms: Inability to bear weight, Popping, Stiffness, Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness

Change since last visit: Improved Unchanged Worse

Has had this pain before? yes no multiple times once years ago

Pain made worse by: sitting Standing Walking Riding in a car

Lifting Twisting Working overhead Bending

Pain improved by: Rest Heat Ice Medication Physical therapy

Chiropractic treatments Home exercise program

Fig 11

PAIN DESCRIPTION: _____ R L RL

Pain Description: Throbbing Stabbing Burning Dull/Aching

Sharp

Radiation (Cervical and lumbar): Shoulder R/L Arm R/L Hand R/L

Buttock R/L Thigh R/L Calf R/L Foot R/L

Pain is made worse with cough or sneeze? yes no

Loss of control of bowel or bladder? yes no

Other symptoms: Inability to bear weight, Popping, Stiffness, Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness

Change since last visit: Improved Unchanged Worse

Has had this pain before? yes no multiple times once years ago

Pain made worse by: sitting Standing Walking Riding in a car

Lifting Twisting Working overhead Bending

Pain improved by: Rest Heat Ice Medication Physical therapy

Chiropractic treatments Home exercise program

PAIN DESCRIPTION: _____ R L RL

Pain Description: Throbbing Stabbing Burning Dull/Aching

Sharp

Radiation (Cervical and lumbar): Shoulder R/L Arm R/L Hand R/L

Buttock R/L Thigh R/L Calf R/L Foot R/L

Pain is made worse with cough or sneeze? yes no

Loss of control of bowel or bladder? yes no

Other symptoms: Inability to bear weight, Popping, Stiffness, Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness

Change since last visit: Improved Unchanged Worse

Has had this pain before? yes no multiple times once years ago

Pain made worse by: sitting Standing Walking Riding in a car

Lifting Twisting Working overhead Bending

Pain improved by: Rest Heat Ice Medication Physical therapy

Chiropractic treatments Home exercise program

PHYSICAL EXAMINATION

Cervical spine _____

Shoulder _____

Elbow _____

Wrist _____

Hand _____

Thumb _____

Index finger _____

Long finger _____

Ring finger _____

Fifth finger _____

Strength upper _____

Reflex upper _____

Measurements upper _____

Pulses upper _____

Jaymar _____

Lumbar spine _____

Thoracic spine _____

Hips _____

Knees _____

Ankles and feet _____

Great toe _____

Second _____

Third _____

Fourth _____

Fifth _____

Straight leg raising _____

Measurements lower _____

Strength lower _____

Reflex lower _____

Pulses lower _____

Osten 1 _____

Osten 2 _____

Osten 3 _____

Fig 12

304

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Areas of tenderness:
Areas of erythema:
Areas of swelling:
Areas of ecchymosis:

GENERAL APPEARANCE

Cervical lordosis: present/absent location
Muscle spasms: present/absent location
Contusions: present/absent location
Scars: present/absent location

RANGE OF MOTION OF THE CERVICAL SPINE

Flexion: 0-20
Extension: 0-20
Rotation (R): 0-90
Rotation (L): 0-90
Lateral bend (R): 0-20
Lateral bend (L): 0-20

SHOULDER

Flexion: 0-180
Extension: 0-180
Abduction: 0-180
Adduction: 0-90
Internal rotation: 0-90
External rotation: 0-90
Crepitation: neg
Thumb to in extension

ELBOW

Flexion/Extension: 0-135
Supination: 0-90
Pronation: 0-90
Pain on extension of wrist no
Pain on flexion of wrist no

WRISTS AND HANDS

Flexion: 0-90
Extension: 0-90
Ulnar deviation: 0-35
Radial deviation: 0-15
Tinel's (cte) neg
Finkelstein's neg
Phalen's (cte) neg
O test: neg
Thenar atrophy (cte) neg
Hypothenar atrophy (cte) neg
Crepitation: neg
Palpable spurs: no
Ganglions: no
volar no
dorsal no

THUMB AND FINGER

M. P. 0-90
Crepitation: neg
Palpable spurs: neg
Instability: neg
P. I. P. 0-90
Crepitation: neg
Palpable spurs: neg
Instability: neg
D. I. P. 0-90
Crepitation: neg
Palpable spurs: neg
Instability: neg
Trigger finger: neg

MUSCLE STRENGTH DETERMINATION

Deltoid - Ant. 5/5
Deltoid - Med. 5/5
Shoulder Int. rotation: 5/5
Shoulder Ext. rotation: 5/5
Biceps: 5/5
Triceps: 5/5
Brachial radialis: 5/5
Wrist flexors: 5/5
Finger flexors: 5/5
Finger extensors: 5/5
Intrinsics: 5/5

WATSON

Grip strength: /
Lateral pinch: /
Chuck pinch: /

REFLEX REACTION

Biceps: 2+
Triceps: 2+
Pectoral: 2+
Brachial radialis: 2+

SENSATION

normal

PULSES

Radial: 2+
Ulnar: 2+
Maintained with shoulder abduction: yes

MEASUREMENTS

Upper arm (5" above the olecranon): RIGHT
Lower arm (5" below the olecranon): RIGHT

Fig 13

Fig 14

312

LOCATION **X-RAY** **NOF VIEWS (1-5)** **N/A**

A-Cervical spine B-Thoracic spine C-Lumbar spine D-Shoulders
E-Humerus F-Elbow G-Forearm H-Wrist I-Hand J-Thumb
K-Finger L-Hip M-Femur N-Knee O-Tibia P-Ankle Q-Foot

ABNORMALS A B C

Cervical, Lumbar and Thoracic spine:
Alignment is normal/abnormal.
Paravertebral soft tissues are normal/abnormal.
Lordosis is normal/abnormal.
The intervertebral disc spaces are maintained/narrow.
Evidence of congenital: yes/no
Evidence of degenerative: yes/no
Evidence of post-traumatic abnormalities: yes/no

OTHER

The bony contours are normal/abnormal.
Consistency is normal/osteoporotic/abnormal.
The cortex is intact/disrupted.
Disrupted at _____

Joint surfaces are: Normal Irregular
Contour: Normal Narrowed
Height: Present Absent
Spurs: _____

Other

Fractures

1. The fracture alignment is satisfactory.
2. The fracture alignment is satisfactory with good callus.
3. Free bodies.
4. Retained surgical metal.

Fig 17

314

DIAGNOSIS

The patient was instructed in a home exercise program. yes no
PHYSICAL THERAPY Ordered Continued Changed Discontinued None
L-Lumbar Program C-Cervical Program B-Back School R-Electrostim
I-Iontophoresis Q-Quadriceps Program R-Range of Motion
S-Strengthening K-Knee O-Other _____ weeks.

_____ was discussed in detail, including complications, alternatives and prognosis.

Scheduled at/for _____

Chiropractic care was discussed with patient? Y/N

Medication prescribed: _____

Testing ordered: _____

Referral initiated or requested to _____

for _____

DISCUSSION

CURRENT STATUS

- A. Working without limitations B. Working with limitations
- C. Not working R. Retired S. Student
K. Child H. Housewife
If the patient is not working:
D. Released for work on _____ (date)
E. Estimated time before released for work. # _____ W M

DISABILITY STATUS

- A. Temporarily partially disabled with no expectation of permanent disability.
F. Temporarily partially disabled with expectation of some level of permanent disability.
B. Temporarily totally disabled.
C. Permanent and stationary with no disability.
D. Permanent and stationary with rateable disability.
E. Permanent and stationary with permanent factors of disability.

VOCATIONAL REHABILITATION

- A. There is a need for vocational rehabilitation. yes/no
B. There is no need for vocational rehabilitation. yes/no
C. The need for vocational rehabilitation cannot be determined at this time.

RETURN VISIT _____ D for Days _____ W for Weeks _____ M for Month FRN
Reason for return visit: X-ray CXR Recheck Suture removal
Staple removal Test results Surgery Video Review Post Op H & P

Fig 18

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DISCUSSION: The treatment program was reviewed. Physical therapy has been continued to include: strengthening, range of motion, and knee program 3 times a week for 3 weeks. Present medication prescribed: Vicodin. I have given the patient a prescription for a thermophore for her lumbar spine pain, due to physical therapy for the right knee.

CURRENT STATUS: The patient is not working.

DISABILITY STATUS: The patient is temporarily totally disabled.

RETURN VISIT: The patient will return in 1 week for a post-op visit.

Sincerely,

Fig 20

330

DATE

NAME

ADDRESS

STATE ZIP

Re:
Emp:
DOI:
SSN:
CL#:

Dear Sir/Madam:

HISTORY: The patient is a XX-year-old Caucasian female who is returning for a postoperative visit, regarding complaints referable to the knee. The patient was injured in a work related accident on XX/XX/XX. The patient was last seen on XX/XX/XX. The patient underwent an arthroscopy, partial lateral and medial meniscectomy, and chondral debridement of the right knee on XX/XX/XX.

CURRENT COMPLAINTS: The right knee pain is a dull aching type. Other symptoms include: stiffness, soreness, numbness, and swelling. Her pain is improved by ice. Her pain is made worse by standing, walking, and bending. The patient has night pain which renders her unable to sleep.

SPECIAL STUDIES: None.
ALLERGIES: No known drug allergies.
CURRENT MEDICATION: Motrin.

PHYSICAL EXAMINATION: Right
KNEE EXAMINATION: Right
Flexion/Extension: 0-120 degrees

X-RAY: None taken today.

DIAGNOSIS:

- 836.0 Medial meniscus tear, post arthroscopy, partial medial meniscectomy with chondral debridement, right knee.
- 836.1 Lateral meniscus tear, post arthroscopy, partial lateral meniscectomy, right knee.
- 716.36 Osteoarthritis of the right knee.

Fig 19

DATE
NAME
ADDRESS
STATE ZIP

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XX/XX/XX
RE:

HISTORY: The patient is a XX-year-old Caucasian male who is returning for a follow-up visit, regarding complaints referable to the hips. The patient was last seen on XX/XX/XX. Since his last visit he has taken a Medrol Dose Pack.

CURRENT COMPLAINTS: The patient denies any right hip pain. This has improved since his last visit.

The patient's left hip pain is a dull aching type. Other symptoms include soreness. This has improved since his last visit. His pain is improved by rest and medication. His pain is made worse by sitting, lifting, twisting, bending, and walking. The patient does not have night pain which awakens him.

SPECIAL STUDIES: None.

ALLERGIES: Codeine and Penicillin.

CURRENT MEDICATION: Antibiotics, Lanoxin, and Tagamet.

PHYSICAL EXAMINATION:

hips: Right Left
Flexion: 0-90 0-90 degrees
Areas of tenderness: ischial tuberosity, left
Areas of erythema: none
Areas of swelling: none
Areas of ecchymosis: none

X-RAY: None taken today.

DIAGNOSIS:

912.00 Abrasion of the left arm, healed.

716.95 Osteoarthritis, post total hip arthroplasty, left.

820.21 Greater trochanter fracture, right hip.

DISCUSSION: The treatment program was reviewed. No physical therapy was ordered.

CURRENT STATUS: The patient is retired.

RETURN VISIT: The patient will return in 2 weeks for a follow-up visit.

Fig 21

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INITIAL EXAM AND ANNUAL UPDATE									
NAME		AGE		DATE		NAME		DATE	
Physical Examination		Height		Weight		B.P.		LMP	
Normal		Abn		HE		Chest and distal all positive findings below		Gn	
1. Ext. genitalia									
2. Vagina									
3. Cervix									
4. Uterus (describe)									
5. Adnexa									
6. Rectum									
7. Other									
General Physical									
8. Skin									
9. HEENT									
10. Neck									
11. Chest									
12. Breasts									
13. Heart									
14. Lungs									
15. Abdomen									
16. Musculoskeletal									
17. Extremities									
18. Neurologic									
LAB PERFORMED:		HCT		UA		CULTURE: URINE HERPES BIO/CULT CHLAMYDIA			
PAP		WET MOUNT		LABSCAN		PREG		OTHER:	
Diagnosis and Treatment Plans									

Fig 22

NAME: DATE: INITI:

This ___ year old G ___ P ___ A ___ T ___ ^{new} returning pt is here for:

- ☐ Annual exam and pap smear
- ☐ Recheck of : _____
- ☐ _____ procedure for _____
- ☐ Pre-op ☐ Post-op visit for _____ Date / /

Her LMP was / / , cycles are ☐ reg every ___ days
☐ 19 due to natural onset of menopause, ☐ irreg (describe)
☐ 19 Status/post ☐ TAH ☐ TVH ☐ BSO for: _____

She has complaints of:
 (signs/symptoms)
 (type/duration)
 (home/other tx)
 (other info)

She is also concerned/has questions regarding :

1* Her birth control method is: ☐ BCS ☐ ☐ ☐
☐ Btl/hyst ☐ Depo-Provera
☐ vasectomy ☐ Norplant ☐ abstinence
☐ condoms ☐ none ☐ trying for pregnancy

2* She currently is / is not on ERT.

Last annual & pap data and results / / ☐ NL ☐ Abn

Past medical and operative hx was reviewed.

Significant finding include:
 (Chronic/serious illness)
 (Previous operations)

She sees Dr. _____
 for problems / 1 2 3 4 5

Dr. _____ is her family phy.

1. _____ CURRENT MEDS & DOSAGES

2. _____

3. _____

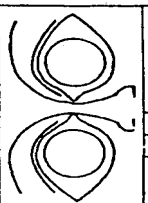
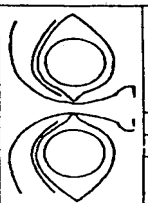
4. _____

5. _____

Fig 23

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DOB		NAME		DATE		PH	
OCCUPATION		AGE - SEX - HSE		CC		CC	
FAMILY NO.		ADDRESS		VOS		PH	
REPORTED BY		DATE		CC		PH	
WCD		C/O		VOD		PH	
-OS				VOS		PH	



1. PAST EYE EX	12. EOS (J-1)	23. VITREOUS
2. EYE A.D.	13. NPC	24. LENS
3. GLAUCOMA	14. VERSIONS	25. IRRIS
4. DISEASE	15. ACT	26. DISC
5. INJURY	16. CT	27. CUP
6. GENL. EX	17. HIRSCHBERG	28. MACULA
7. DIA. HBP	18. PUPILS/ERRA	29. FUNDUS
8. MEDICATION	19. CONJUNCT	30. SPECIAL EXAM
9. ALLERGY	20. CORNEA	31. REFRA SUBJ
10. HOSP. M-S	21. SCLERA	32. RED LENS
11. LAST H & P	22. A.C.	33. VF - H-F
12. VOT. EX	23. VITREOUS	34. TONOMETRY
13. EYE EXAM	24. LENS	
14. EOS (J-1)	25. IRRIS	
15. NPC	26. DISC	
16. VERSIONS	27. CUP	
17. ACT	28. MACULA	
18. CT	29. FUNDUS	
19. HIRSCHBERG	30. SPECIAL EXAM	
20. PUPILS/ERRA	31. REFRA SUBJ	
21. CONJUNCT	32. RED LENS	
22. CORNEA	33. VF - H-F	
23. SCLERA	34. TONOMETRY	

Fig 24

EYE
EXAM

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WORKER'S COMPENSATION HISTORY

PATIENT'S NAME _____

ADDRESS _____ street address _____ city _____ zip code _____

HOME PHONE _____ DATE OF BIRTH _____

MARITAL STATUS _____ SEX _____ AGE _____ RIGHT OR LEFT HANDED _____

NUMBER OF CHILDREN LIVING AT HOME _____

SOCIAL SECURITY NUMBER _____

OTHER NAMES USED PREVIOUSLY _____

PATIENT REFERRED BY: (i.e. insurance co., physician, attorney, state of California) include address: _____

EMPLOYER at time of accident _____

ADDRESS _____ street address _____ city _____ zip code _____

HOW LONG WERE YOU EMPLOYED: _____

NUMBER OF HOURS AND DAYS WORKED PER WEEK: _____

JOB DESCRIPTION: _____

JOB ACTIVITIES: _____

SITE OF ACCIDENT IF DIFFERENT FROM ABOVE: _____

ACCIDENT DATE: _____ ACCIDENT TIME: _____

DATE FIRST TREATED: _____ WERE YOU DRIVING A COMPANY VEHICLE _____

DATE LAST WORKED: _____

DATE RETURNED TO WORK: _____

Fig 25

358

WORK RESTRICTIONS, IF ANY:

PRESENT EMPLOYER: _____

ADDRESS:	street address	city	zip code

DATE OF EMPLOYMENT: _____

PHONE: _____

JOB DESCRIPTION	DUTIES	REMARKS

JOB ACTIVITIES

Describe fully the accident: _____

Describe any equipment and/or machinery involved: _____

Describe your physical complaints immediately following this accident:

Head: _____

Neck:

Back:

Answer:

10

47926

360

Did you report the injury to your employer? Yes___ No___

To whom and when did you report this injury? _____

Were you treated at the company dispensary, given first aid, or sent elsewhere? _____

Name and addresses of witnesses to the accident _____

How did you get to a place of treatment? _____

Did you go home or continue working? Yes___ No___

TYPE OF TREATMENT RECEIVED SINCE THE ACCIDENT: (include hospital, surgeries, physical therapy, chiropractic therapy or any other treatment)

DOCTOR OR FACILITY	WHEN SEEN	NATURE OF TREATMENT	DID TREATMENT HELP?	X-RAYS TAKEN
			Y N	Y N

Other tests performed: (MRI, CT scans, arthrogram, BMC)

Yes _____ No _____

that where tests were performed below:

Worker's Compensation
Page 3

Fig 27

362

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What medications have been prescribed and give results:

MEDICATION _____ RESULTS _____

DIAGNOSIS GIVEN:

Describe fully all present complaints:

COMPLAINT _____ (IMPROVED/WORSE/UNCHANGED) PAIN RATING (0-10) _____

Head: _____

Neck: _____

Back: _____

Arms: _____

Legs: _____

IF YOU HAVE HEADACHES PLEASE ANSWER THE FOLLOWING QUESTIONS:

How often do you have headaches? _____

How long do they last? _____

Do you have _____
(circle appropriate symptom(s)) Light-headedness, ringing in ears, visual blurring, nervousness, or trouble sleeping.

Worker's Compensation
Page 4

Fig 28

What part of your head hurts? _____

What (if any) medications do you take for the headache and how often do you take them? _____

IF YOU HAVE NECK PAIN PLEASE ANSWER THE FOLLOWING QUESTIONS:

(circle appropriate symptom(s)) bending head forward, looking up, turning head from side to side, reaching up, lifting, pushing, or pulling.

IF YOU HAVE BACK PAIN, PLEASE ANSWER THE FOLLOWING QUESTIONS:

How long can you sit in one place before the back pain becomes intolerable? _____

How long can you stand in one place before the back pain is intolerable? _____

How long can you walk before the back pain is intolerable? _____

How long can you remain bent over to do repeated bending before the back pain is intolerable? _____

What is the greatest weight you can lift without increasing your back pain? _____

Does overhead work, reaching, pushing or pulling cause an increase in the back pain? _____

Worker's Compensation
Page 5

Fig 29

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Does the pain go into your arms or legs, if yes, which ones

and what activities cause this to occur?

Do you experience numbness in the legs, if yes (does it)

1. travel down the front of the legs?
2. travel down the back of the legs?
3. travel into the toes, if yes, which ones
4. is the numbness present constantly
5. when did this symptom start

ALL PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

What medications are you currently taking?

Do you have other mental, physical, or emotional problems which might have caused, been aggravated, or resulted from this accident?

RESTRICTED SOCIAL ACTIVITIES:

List any social/sports activities that you can no longer do or have had to significantly limit due to this injury (i.e.: housework, gardening, child care)

ACTIVITY DESCRIBE HOW YOU ARE RESTRICTED

Fig 30

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PRIOR WORK RELATED INJURIES:

List prior or past illnesses and/or surgeries. List name and addresses of employers (include dates and nature of injury, fractures, lacerations, contusions, auto accidents).

List dates you stopped working because of this accident.

Did you return to work? Yes No

If so, date you returned to work?

Work restrictions if any?

Fig 31

869010" 85620060

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PAST MEDICAL HISTORY: -- Indicate if you have had any of the following:

	Yes	No
Measles, Mumps, Chickenpox		
Eye Problems		
Ear, Nose, Throat Problems		
Respiratory Problems		
Cancer		
Heart Disease		
High Blood Pressure		
Arthritis		
Gout		
Urinary/Kidney Problems		
Liver Disease		
Stroke		
Diabetes		
Epilepsy		
Circulation Problems		
Stomach/Ulcer Problems		
Alcoholism/Drug Abuse		
Psychological Problems		

Industrial Injuries -- Have you ever been injured on the job other than what you are being examined for today?

Yes ___ No ___

If yes, please list below:

YEAR	EMPLOYER	INJURED AREA	RECOVER?	IF NOT, DESCRIBE

Fig 32

PRIOR PERSONAL INJURIES:

Automobile Accidents -- Please indicate if you have ever been involved in one either before or after the date of accident for which you are being seen.

Yes ___ No ___

If yes, please list below:

YEAR	INJURED AREA/BODY PART	DID YOU RECOVER?	IF NOT, DESCRIBE

Other Injuries -- List any major accidents/injuries other than listed above (includes broken bones).

YEAR	INJURED AREA/BODY PART	DID YOU RECOVER?	IF NOT, DESCRIBE

Surgeries -- List any surgeries you have had performed.

YEAR	AREA OF BODY	DID YOU RECOVER?	IF NOT, LIST REASON

List any allergies to foods or medications

If you smoke cigarettes how long have you smoked and how much do you smoke?

Fig 33

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If you drink alcohol how much do you routinely consume? _____

EDUCATION HISTORY:

Fig 34

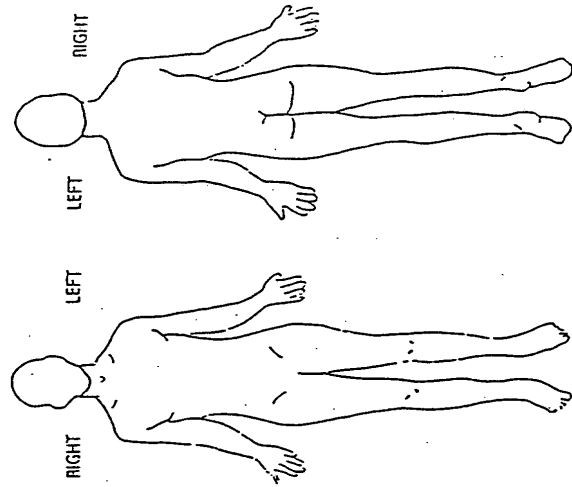
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PAIN DIAGRAM

Using the figures below, mark the areas where you feel the described sensations are on your body. Use the appropriate symbol(s) and include **all** the affected areas.

Dominant hand: — Left — Right

ACHIE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
+++	-----	00000	VVVVV	//////
+++	-----	00000	VVVVV	//////



PLEASE SELF RATE YOUR PAIN BY BODY PART, BASED ON A SCALE OF 0-10, 10 BEING THE WORST PAIN YOU HAVE EVER EXPERIENCED, WHAT IS YOUR PAIN LEVEL TODAY.

BODY PART	PAIN LEVEL
BODY PART	PAIN LEVEL
BODY PART	PAIN LEVEL
BODY PART	PAIN LEVEL

Fig 35

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Jobs Held In The Past

Starting with the most recent:

DATE EMPLOYER JOB TITLE DUTIES

Did you have any injuries or receive medical treatment at these jobs (Workers' Compensation Disability payments)? Yes ___ No ___

If yes, when? _____

Where? _____

Thank you for helping us with your history.

Form completed by: _____ Date: _____

Signature

Assisted by: _____

Fig 36

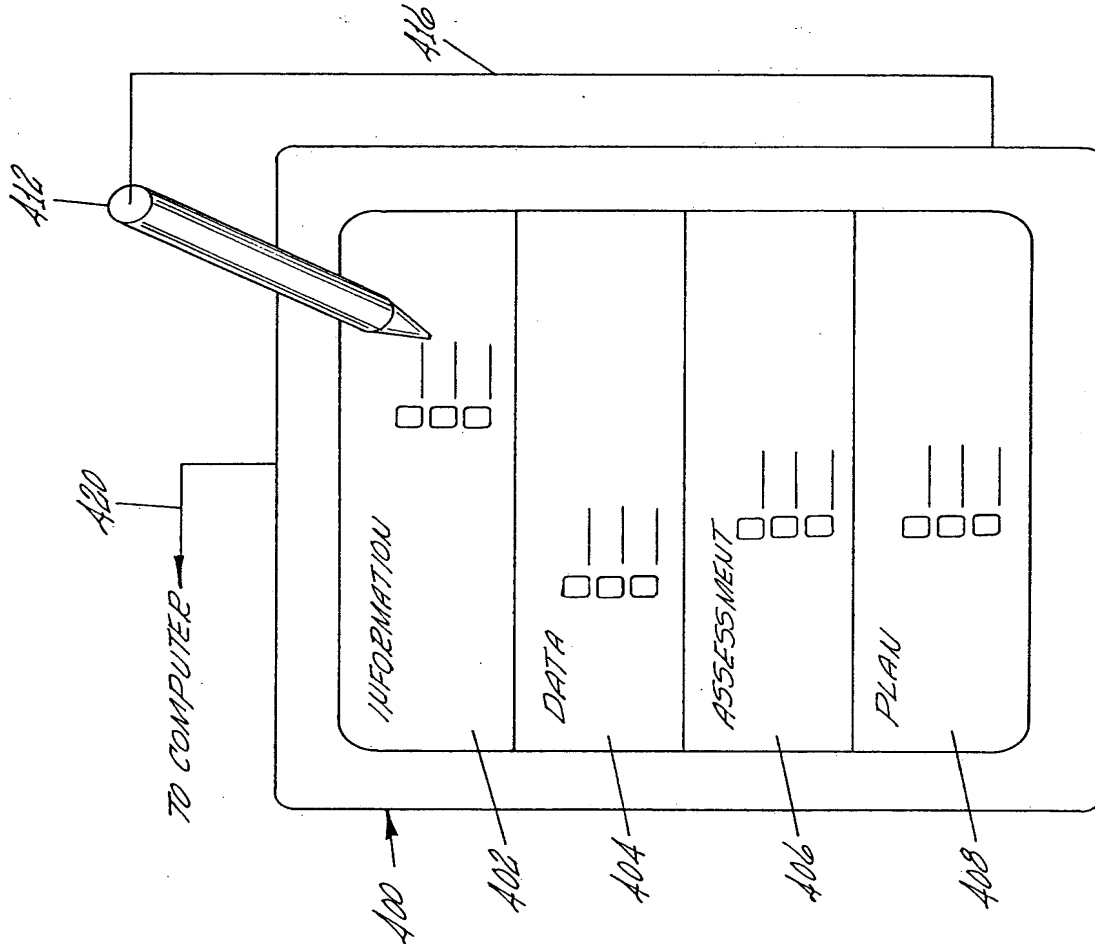


Fig 37